

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

0051125 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 356 Primary Registration District No. 4521 Registrar's No. 11

FILED 23 64

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Texas</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>Texas</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Houston</u>			Length of stay in 1b		c. CITY OR TOWN <u>Hatchorn</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>Texas Co Memorial</u>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>Hatchorn</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ordie</u> Middle <u>E</u> Last <u>Murphy</u>			4. DATE OF DEATH Month <u>12</u> Day <u>23</u> Year <u>1963</u>					
5. SEX <u>Male</u>	6. COLOR OF RACE <u>Wh</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12/20/1881</u>	9. AGE (last birthday) <u>82</u>	IF UNDER 1 YEAR Months <u>-</u> Days <u>2</u>	IF UNDER 24 HR Hours <u>-</u> Min. <u>-</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Postsmouth, Ohio</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13a. FATHER'S NAME <u>James W. Murphy</u>			13b. MOTHER'S MAIDEN NAME <u>Lettishia Teaner</u>			14. NAME OF HUSBAND OR WIFE <u>Sally Ann Crabtree</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>[Redacted]</u>	17. INFORMANT <u>Pearl Stewart</u> <u>Summersville Mo</u>				
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombotic Circulatory Failure</u>							INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) <u>Arteriosclerotic Valvular heart disease</u>					
			DUE TO (c) <u>Phlebitis (both legs)</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)				
20c. TIME OF INJURY Hour <u>-</u> a.m. <u>-</u> p.m. <u>-</u>	Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE	
21. I attended the deceased from <u>1946</u> , to <u>1963</u> and last saw ^{her} him alive on <u>Dec 21-1963</u> Death occurred at <u>8:30 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Dr. Lawrence Bechtel D.O.</u>				22b. ADDRESS <u>Summersville Mo</u>		22c. DATE SIGNED <u>1-18-64</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-26-1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Antioch</u>		23d. LOCATION (City, town, or county) <u>3 1/2 m. n.w. Hatchorn, Mo</u>			(State)	
24. FUNERAL DIRECTOR <u>L. J. Evans</u>		ADDRESS <u>Houston Mo</u>	25. DATE RECD. BY LOCAL REG. <u>1-21-64</u>	26. REGISTRAR'S SIGNATURE <u>Myrtie Craig (Mag. Owen Dep)</u>				

USE BLACK INK OR TYPEWRITER RIBBON

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JAN 27 1964

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Will C. Craig*

Licensed Embalmer No. 4766

P. O. Address *Mtn Grove, Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.